

# I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## =60-014593

LED VS. MAY 2 1960 75

Registration District No. 3010

Registrar's No. 45

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clinton</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cameron</b>		Length of stay in 1b <b>8 Days</b>		c. CITY OR TOWN <b>Cameron</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cameron Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>516 N. Mulberry</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Alta</b> Middle <b>Mae</b> Last <b>Leeper</b>				4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1960</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9/17/86</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Daviess Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Cowin M. Brown</b>			13b. MOTHER'S MAIDEN NAME <b>Eva Mason</b>			14. NAME OF HUSBAND OR WIFE <b>Roy Leeper</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Gene Leeper</b>			Address <b>Cameron, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause (last). DUE TO (b) <b>chronic coronary atherosclerosis</b>							<b>5 yrs.</b>		
DUE TO (c) <b>Generalized arteriosclerosis</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>Hypertension</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <b>4-2-60</b> to <b>4-26-60</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>4-26-60</b> Death occurred at <b>10:20 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>M. J. Compton M.D.</b>				22b. ADDRESS <b>Cameron, Mo.</b>		22c. DATE SIGNED <b>4-28-60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/28/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Kidder Cemetery</b>			23d. LOCATION (City, town, or county) <b>Kidder, Mo.</b>				
24. FUNERAL DIRECTOR <b>Morris A. Bram</b>				ADDRESS <b>Hamilton, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4-29-60</b>		26. REGISTRAR'S SIGNATURE <b>Francis D. Bradford</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Marrie A. Br

Licensed Embalmer No. 3918

P. O. Address Hamilton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.